

**AMBULANCE SERVICES
TABLE OF CONTENTS**

	Page #
I. GENERAL INFORMATION	
A. TYPE OF HANDBOOK	1Q1-001
B. PROVIDER INFORMATION	1Q1-001
Provider Eligibility and Certification	1Q1-001
Ambulance	1Q1-001
Separate Certification	1Q1-001
Air Ambulance	1Q1-001
Scope of Service	1Q1-001
Reimbursement	1Q1-001
Available Transportation Services	1Q1-002
Public Common Carrier/Private Motor Vehicle Program	1Q1-002
Specialized Motor Vehicle (SMV)	1Q1-002
Ambulance	1Q1-002
Provider Responsibilities	1Q1-003
C. RECIPIENT INFORMATION	1Q1-003
Eligibility For Medical Assistance	1Q1-003
Medical Status	1Q1-003
Medicare/Medical Assistance Dual Entitlement	1Q1-003
Medicare QMB-Only Coverage	1Q1-003
Health Maintenance Organization (HMO) Coverage	1Q1-004
Copayment	1Q1-004
II. COVERED SERVICES & RELATED LIMITATIONS	
A. INTRODUCTION	1Q2-001
B. COVERED AMBULANCE SERVICES	1Q2-001
Emergency Ambulance Services	1Q2-001
Air and Water Transportation	1Q2-002
Nonemergency Ambulance Services	1Q2-002
Waiting Time	1Q2-002
Life Support Services	1Q2-002
Additional Attendant Services	1Q2-003
Isolettes	1Q2-003
First Aid at the Scene	1Q2-003
C. NONCOVERED SERVICES OR RELATED LIMITATIONS	1Q2-003
Noncovered Ambulance Services	1Q2-003
III. PRIOR AUTHORIZATION	
A. GENERAL REQUIREMENTS	1Q3-001
B. SERVICES REQUIRING PRIOR AUTHORIZATION	1Q3-001
C. PROCEDURES FOR OBTAINING PRIOR AUTHORIZATION	1Q3-001

AMBULANCE SERVICES
TABLE OF CONTENTS
(continued)

	Page #
IV. BILLING INFORMATION	
A. OTHER THIRD PARTY LIABILITY (TPL) COVERAGE	1Q4-001
B. MEDICARE/ MEDICAL ASSISTANCE DUAL ENTITLEMENT	1Q4-001
C. QMB-ONLY RECIPIENTS	1Q4-001
D. BILLED AMOUNTS	1Q4-001
E. CLAIM SUBMISSION	1Q4-001
Paperless Claim Submission	1Q4-001
Paper Claim Submission	1Q4-001
F. DIAGNOSIS CODES	1Q4-002
G. PROCEDURE CODES	1Q4-002
H. FOLLOW-UP TO CLAIM SUBMISSION	1Q4-002
V. APPENDICES	1Q5-001

PART Q, DIVISION I AMBULANCE SERVICES	SECTION I GENERAL INFORMATION	ISSUED 03/93	PAGE 1Q1-001
--	----------------------------------	-----------------	-----------------

A. TYPE OF HANDBOOK

Part Q, Division I, is the Ambulance Handbook of the Wisconsin Medical Assistance Program (WMAP), to be used with the Part A handbook.

<p>Part Q, Division I, contains:</p> <ul style="list-style-type: none"> - provider eligibility criteria; - recipient eligibility criteria; - covered services; - reimbursement information; and - billing instructions. 	<p>Part A contains:</p> <ul style="list-style-type: none"> - general policy guidelines; - regulations; - telephone numbers and addresses; and - billing information applicable to all providers certified in the WMAP.
--	--

B. PROVIDER INFORMATION

Provider Eligibility and Certification

Ambulance

Per section HSS 105.38, Wis. Admin. Code:

"For Medical Assistance certification, ambulance service providers shall be licensed pursuant to s. 146.50, Stats., and ch H 20 (HSS 110), and shall meet ambulance inspection standards adopted by the Wisconsin Department of Transportation under s. 341.085, Stats., and found in ch. Trans 157."

Ambulance providers who are granted border status and who do not provide services in Wisconsin are exempt from the Wisconsin licensure requirement, but must be licensed by the appropriate agency in the state in which they provide services. Section 105.48, Wis. Admin. Code, explains which provider may be granted border status.

Separate Certification

All ambulance providers who operate either air ambulance or specialized medical vehicles (SMV) must obtain separate certification for each service, in order to bill for these services.

Air Ambulance

An air ambulance service must be licensed by the Division of Health pursuant to s. 146.50 Wis. Stats.

Scope of Service

The policies in Part Q, Division I, govern services provided within the scope of the practice of the profession as defined in ss. 49.46, Wis. Stats. and Chapter HSS 107.23, Wis. Admin. Code. Covered services and related limitations are listed in Section II of this handbook.

Reimbursement

Providers can bill the WMAP for covered services only if the services are also billed to non-Medical Assistance recipients.

Ambulance providers are reimbursed by maximum allowable fees for all covered ambulance services provided to WMAP recipients eligible on the date of service. The maximum allowable fees are based on three geographic reimbursement areas:

PART Q, DIVISION I AMBULANCE SERVICES	SECTION I GENERAL INFORMATION	ISSUED 03/93	PAGE 1Q1-002
--	--	-------------------------	-------------------------

**B. PROVIDER
INFORMATION
(continued)**

- statewide/out-of-state;
- metropolitan professional; and
- Milwaukee county.

Ambulance providers must bill their usual and customary charges for the services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to non-Medical Assistance recipients.

Available Transportation Services

The following types of transportation are available to WMAP recipients:

Public Common Carrier/Private Motor Vehicle Program

The WMAP does not reimburse providers for this type of transportation. The local tribal or county social and human service agencies reimburse the recipient. For more information on this program, contact the local county department of social or human services.

This type of transportation includes:

- car;
- airplane;
- train;
- bus; or
- taxi.

This form of transportation is used when:

- the recipient is physically and mentally able to take this form of travel without the assistance of another person;
- a child of any age is able to take a bus, airplane, train, taxi, or car with an adult; and
- the local county department of social and human service agency approves the service.

Specialized Motor Vehicle (SMV)

SMV transportation is a WMAP-covered benefit to be used when the recipient is disabled and is unable to take public common carrier or private motor vehicle transportation and the purpose of the trip is to receive WMAP-covered medical services.

If the recipient is enrolled in an HMO, contact the HMO for coverage information. Refer to Section I-C of this handbook for additional WMAP eligibility information.

Ambulance

Ambulance transportation is:

- licensed by the Department of Health and Social Services;
- a covered emergency transport, usually to the hospital; or
- a covered non-emergency transport when the recipient has a significant medical condition or a need for medical monitoring that does not allow common carrier, private motor vehicle, or specialized motor vehicle transportation.

Ambulance transportation providers are separately certified.

PART Q, DIVISION I AMBULANCE SERVICES	SECTION I GENERAL INFORMATION	ISSUED 03/93	PAGE 1Q1-003
--	----------------------------------	-----------------	-----------------

**B. PROVIDER
INFORMATION
(continued)**

Provider Responsibilities

Specific WMAP provider responsibilities are stated in Section IV of the WMAP Part A Provider Handbook. Reference Section IV of Part A for detailed information regarding:

- fair treatment of the recipient;
- maintenance of records;
- recipient requests for noncovered services;
- services rendered to a recipient during periods of retroactive eligibility;
- grounds for provider sanctions; and
- additional state and federal requirements.

**C. RECIPIENT
INFORMATION**

Eligibility For Medical Assistance

The identification cards include:

- the recipient's name;
- date of birth;
- 10-digit Medical Assistance identification number; and
- when applicable, indicator of private health insurance coverage, HMO coverage, Medicare coverage, and Medicare QMB-Only coverage.

The Medical Assistance identification cards are:

- sent to recipients monthly; and
- valid only through the end of the month for which they are issued.

It is important that the provider or the designated agent check a recipient's Medical Assistance identification card prior to providing service to determine the recipient's eligibility and if there are any limitations to the recipient's coverage.

Section V-C of the WMAP Part A Handbook provides detailed information on:

- Medical Assistance eligibility;
- identification cards, temporary cards, and restricted cards; and
- how to verify eligibility.

A sample Medical Assistance identification card is in Appendix 7 of the WMAP Part A Handbook.

Medical Status

Medical Assistance recipients are classified into one of several eligibility categories. These categories allow for a differentiation of benefit coverage. Refer to Section V of the WMAP Part A Provider Handbook for additional medical status information.

Medicare/Medical Assistance Dual Entitlement

Recipients covered under both Medicare and Medical Assistance are referred to as dual-entitlees. Providers can identify Medicare recipients by an "A" or "B" on the Medical Assistance identification card. See Appendix 7 of the WMAP Part A Handbook for an example.

Medicare QMB-Only Coverage

Providers can identify Qualified Medicare Beneficiary Only (QMB-Only) recipients by the presence of "QMB-Only", or "QMB-Only NH" (nursing home residents) on the Medical Assistance identification card. QMB-Only recipients are only eligible for WMAP payment of the coinsurance and the deductibles for Medicare covered services.

PART Q, DIVISION I AMBULANCE SERVICES	SECTION I GENERAL INFORMATION	ISSUED 03/93	PAGE 1Q1-004
--	--	-------------------------	-------------------------

**C. RECIPIENT
INFORMATION
(continued)**

Health Maintenance Organization (HMO) Coverage

WMAF recipients enrolled in WMAF-contracted HMOs receive a yellow Medical Assistance identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's HMO. The codes are defined in Appendices 20, 21, and 22 of the WMAF Part A Provider Handbook.

Providers must check the recipient's current Medical Assistance identification card for HMO coverage before providing services. A sample Medical Assistance identification card can be found in Appendix 7 of the WMAF Part A Handbook. Claims submitted to EDS for services covered by WMAF-contracted HMOs are denied.

For recipients enrolled in a WMAF-contracted HMO, all conditions of reimbursement and prior authorization for ambulance services are established by the contract between the HMOs and certified providers. Ambulance providers, serving WMAF-contracted HMO recipients, should contact the recipient's HMO for further information regarding specific HMO prior authorization and billing information.

Additional information regarding HMO noncovered services, emergency services, and hospitalizations is included in Section IX-E of the WMAF Part A Provider Handbook.

Copayment

Except as noted below, all recipients are responsible for paying part of the costs involved in obtaining non-emergency ambulance services. The procedure codes and their applicable copayment amounts are in Appendix 3 of this handbook.

Providers are reminded of the following copayment exemptions:

- emergency services;
- services provided to nursing home residents;
- services provided to recipients under 18 years of age;
- services provided to a pregnant woman if the services are related to the pregnancy;
- services covered by a WMAF-contracted Health Maintenance Organization (HMO) to HMO enrollees; and
- family planning services and related supplies.

The provider collects the recipient copayment. Applicable copayment amounts are automatically deducted from payments allowed by the WMAF. Do not reduce the billed amount of the claim by the amount of recipient copayment.

PART Q, DIVISION I	SECTION II	ISSUED	PAGE
AMBULANCE SERVICES	COVERED SERVICES & RELATED LIMITATIONS	03/93	1Q2-001

A. INTRODUCTION The Wisconsin Medical Assistance Program (WMAP) covers ambulance transportation when the recipient has an illness or an injury that makes it impossible to use other types of transportation.

B. COVERED AMBULANCE SERVICES **Emergency Ambulance Services**
 Emergency ambulance services are covered when:

- the recipient is transported in an emergency condition resulting from an accident, serious injury, or acute illness (for example, automobile accident, possible hip fracture, severe facial lacerations);
- recipient is in shock;
- recipient is unconscious;
- recipient has difficulty breathing;
- recipient has neck pain, back pain, or a head injury subsequent to significant trauma;
- recipient has chest pains and is over 30 years old, regardless of vital signs;
- recipient is suspected of sustaining an acute stroke or myocardial infarction;
- recipient is experiencing severe hemorrhaging;
- recipient has severe bleeding or bleeding with blood pressure less than 100 systolic (adult);
- recipient has blood pressure of over 100 diastolic with other relevant signs or symptoms;
- recipient has a temperature of greater than 104 orally, 103 axillary, or 105 rectally, with other relevant signs or symptoms;
- recipient has severe burns;
- recipient has severe pain and associated abnormal physiologic changes;
- recipient has suspected poisoning;
- recipient has prolonged or repetitive seizure activity which is observed by ambulance personnel;
- recipient has a bee or other insect sting with significant swelling locally, or any sting in the head area;
- recipient has had a previous or planned cesarean section and is in active labor;
- recipient's delivery has already occurred or the baby's head is presenting;
- recipient is in labor with contractions confirmed as less than four minutes apart, with a history of three or more deliveries, and the bag of waters has broken;
- a prolapsed cord is visible;
- recipient has to remain immobile because of a large bone fracture, or possible fracture, that has not been set.

PART Q, DIVISION I	SECTION II	ISSUED	PAGE
AMBULANCE SERVICES	COVERED SERVICES & RELATED LIMITATIONS	03/93	1Q2-002

**B. COVERED
AMBULANCE
SERVICES
(continued)**

Air and Water Transportation

Emergency and prior authorized non-emergency helicopter, fixed-wing air, and water ambulance services are covered by the WMAP.

Refer to Section III of this handbook for prior authorization information.

Nonemergency Ambulance Services

Nonemergency services are covered if:

- the recipient is confined to bed before and after the ambulance trip (for example, bed-ridden cancer patient going for radiation therapy); or
- the recipient must be moved only by stretcher in order to receive necessary medical services.

A physician's prescription is required indicating that an ambulance transfer is necessary.

The prescription must:

- be obtained prior to transportation;
- be reduced to writing;
- be maintained on file;
- give the reason why the discharging facility was inappropriate for the recipient's condition (for example, the inappropriate facility may not have the equipment, staff, or services needed for the recipient's care).

Transports from a hospital to a nursing home, from one nursing home to another nursing home, or from a recipient's residence to a doctor's or dentist's office are nonemergency transfers. Hospital to hospital transfers are considered nonemergency transfers since the recipient should be in stable condition.

Waiting Time

"Waiting time" is when the ambulance provider is waiting for the recipient to receive medical services and return to the vehicle. It is:

- covered only when a "to" and "from" trip is being billed (round trip);
- limited to a maximum of six hours per date of service;
- may be charged only once when waiting for more than one recipient.

Life Support Services

An ambulance must be used to transport a recipient on life-support systems. The reimbursement is included in the base rate.

The WMAP defines life-support systems as:

- the administration of any prescription medication or IV solution (portable oxygen used by the recipient without the assistance of medical personnel is not considered prescription medication);
- the need for medically-trained personnel (nurse, paramedic, EMT) to monitor and treat the recipient;
- the use of medical equipment (ECG monitor) beyond that specified in HSS 105.39 Wis. Admin. Code.

PART Q, DIVISION I	SECTION II	ISSUED	PAGE
AMBULANCE SERVICES	COVERED SERVICES & RELATED LIMITATIONS	03/93	1Q2-003

**B. COVERED
AMBULANCE
SERVICES
(continued)**

Additional Attendant Services

Services provided by a third ambulance attendant are covered if the recipient's condition requires a third attendant for restraint or lifting.

Isolettes

Transportation of an isolette (incubator) is covered as a nonemergency service when the recipient is under one year of age.

First Aid at the Scene

First aid at the scene is covered when providers make a good-faith response, but the recipient is not transported. Disposable supplies and oxygen may be billed with first aid at the scene. First aid at the scene is not covered when billed with a base rate and mileage charge.

**C. NONCOVERED
SERVICES OR
RELATED
LIMITATIONS**

Noncovered Ambulance Services

The WMAP does not cover:

- additional charges to pick up the recipient's personal belongings;
- vehicle sterilization;
- charges for a recipient's failure to cancel a scheduled transport;
- sales tax;
- transportation of lab specimens;
- extra charges for nights, weekends, or holiday services;
- reusable devices and equipment such as backboards, neckboards, and inflatable splints;
- ambulance trips to obtain physical, occupational or speech therapy, audiology, chiropractic, or psychotherapy services;
- medical personnel who care for the recipient in transit (other than those employed by the ambulance provider);
- excessive mileage;
- trips to facilities where no medical services are received (e.g., day-care center, sheltered workshop);
- no recipient conveyance;
- processes, treatments, or services which are an integral part of care while in transit (complex bandaging procedures, EKG monitoring, drugs used in transit or for starting intravenous solutions);
- trips for the purpose of locating a recipient closer to their family or home;
- trips to relocate a recipient for the sole purpose of improving the recipient's mental, psychological, or emotional health.

PART Q, DIVISION I AMBULANCE SERVICES	SECTION III PRIOR AUTHORIZATION	ISSUED 03/93	PAGE 1Q3-001
--	------------------------------------	-----------------	-----------------

A. GENERAL REQUIREMENTS

Providers must have prior authorization for certain specified services before delivery of that service, unless the service is an emergency.

Payment is not made if:

- services are provided prior to the grant date on the prior authorization request form;
- services are provided after the expiration date on the prior authorization request form;
- services are provided without prior authorization. The provider is then responsible for the cost of the service.

B. SERVICES REQUIRING PRIOR AUTHORIZATION

Prior authorization is required for:

- nonemergency air and water transportation;

Providers are advised that prior authorization does not guarantee payment. Provider eligibility, recipient eligibility, and medical status on the date of service, as well as all other WMAP requirements must be met prior to payment of the claim.

C. PROCEDURES FOR OBTAINING PRIOR AUTHORIZATION

Section VIII of the WMAP Part A Provider Handbook identifies procedures for obtaining prior authorization including emergency situations, appeal procedures, supporting materials, retroactive authorization, and prior authorization for out-of-state providers.

Request prior authorization for ambulance services by submitting a Prior Authorization Request Form (PA/RF) and a Prior Authorization Physician Attachment (PA/PA). Refer to Appendices 5, 6, 7, and 8 of this handbook for sample prior authorization request forms and completion instructions.

Completed prior authorization request forms must be submitted to:

EDS
Attn: Prior Authorization Unit - Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Prior authorization request forms can be obtained by submitting a written request to:

EDS
Attn: Claim Reorder Department
6406 Bridge Road
Madison, WI 53784-0003

Please specify the form requested and the number of forms desired. Reorder forms are included in the mailing of each request for forms. Do not request forms by telephone.

PART Q, DIVISION I AMBULANCE SERVICES	SECTION IV BILLING INFORMATION	ISSUED 03/93	PAGE 1Q4-001
--	-----------------------------------	-----------------	-----------------

- A. **OTHER THIRD PARTY LIABILITY (TPL) COVERAGE** The Wisconsin Medical Assistance Program (WMAP):
- is the payor of last resort ; and
 - reimburses the portion of the allowable cost remaining after all other third party sources have been used.
- Refer to Section IX-D of the WMAP Part A Provider Handbook for more detailed information on services requiring third-party billing, exceptions, and the "Other Coverage Discrepancy Report."
- B. **MEDICARE/ MEDICAL ASSISTANCE DUAL ENTITLEMENT** Recipients covered under both Medicare and Medical Assistance are referred to as dual-entitlees. Claims for Medicare covered services provided to dual-entitlees must be billed to Medicare prior to billing Medical Assistance.
- If the recipient is covered by Medicare, but Medicare denied the claim, a Medicare disclaimer code must be indicated on the claim, as explained in the claim form instructions in Appendix 2 of this handbook.
- C. **QMB-ONLY RECIPIENTS** Qualified Medicare Beneficiary Only (QMB-Only) recipients are only eligible for WMAP payment of the coinsurance and the deductibles for Medicare-covered services. (Since Medicare covers ambulance services, claims submitted for QMB-Only recipients are reimbursed.)
- D. **BILLED AMOUNTS** Providers must bill the WMAP their usual and customary charge for services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to private-pay patients. For providers using a sliding fee scale for specific services, usual and customary means the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Providers may not discriminate against Medical Assistance recipients by charging a higher fee for the service than is charged to a private-pay patient.
- E. **CLAIM SUBMISSION** **Paperless Claim Submission**
- As an alternative to paper claim submission, EDS is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted through these systems have the same legal requirements as claims submitted on paper and are subjected to the same processing requirements as paper claims. Software for electronic submissions may be obtained free of charge. Electronic submissions have substantial advantages in reducing clerical effort and errors, reducing mailing costs and delays, and improving processing time. Additional information on paperless claim submission is available by contacting the Electronic Media Claims (EMC) Department at:
- EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746
- A sample EMC screen can be found in Appendix 1d of this handbook.
- Paper Claim Submission**
- Ambulance services must be submitted using the HCFA 1500 claim form. A sample claim form and completion instructions are in Appendices 1 and 2 of this handbook.
- Ambulance services submitted on any other paper form than the HCFA 1500 claim form are denied.

PART Q, DIVISION I AMBULANCE SERVICES	SECTION IV BILLING INFORMATION	ISSUED 03/93	PAGE 1Q4-002
--	---	-------------------------	-------------------------

**E. CLAIM
SUBMISSION
(continued)**

The HCFA 1500 claim form is not provided by the WMAP or EDS. It may be obtained from a number of forms suppliers including:

State Medical Society Services, Inc.
Post Office Box 1109
Madison, WI 53701
(608) 257-6781
1-800-362-9080

Completed claims submitted for payment must be mailed to:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Submission of Claims

All claims for services rendered to eligible WMAP recipients must be received by EDS within 365 days from the date such service was rendered. This policy pertains to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals are in Section IX-F of the WMAP Part A Provider Handbook.

**F. DIAGNOSIS
CODES**

Ambulance providers must use the appropriate diagnosis code for the service that is provided:

V919 - Emergency
V920 - Nonemergency Prescription on File

**G. PROCEDURE
CODES**

All claims submitted to the WMAP must include procedure codes. HCFA Common Procedure Coding System (HCPCS) codes are required on all ambulance claims. Claims or adjustments received without HCPCS codes are denied. Allowable HCPCS codes and their descriptions for ambulance services are listed in Appendix 3 of this handbook.

**H. FOLLOW-UP
TO CLAIM
SUBMISSION**

It is the provider's responsibility to initiate follow-up procedures on claims submitted to EDS. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Providers are advised that EDS will take no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to EDS. Section X of the WMAP Part A Provider Handbook includes detailed information regarding:

- the Remittance and Status Report;
- adjustments to paid claims;
- return of overpayments;
- duplicate payments;
- denied claims; and
- Good Faith claims filing procedures.